

FILED MAY 1 1947

Registration District No. 52

Primary Registration District No. 3009

Registrar's No. 31

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
 (a) County Cape Girardeau  
 (b) City or town Jackson, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
North Jackson  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 22 years  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Cape Gir 16  
 (c) City or town Jackson 2  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. North Jackson 8  
 (If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Arb King  
 3. (b) If veteran, name war ✓  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month April day 24<sup>th</sup>  
 year 1947 hour 8 minute 30 p.m.

4. Sex Male 2 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Gloria King 6. (c) Age of husband or wife if alive 63 years  
 7. Birth date of deceased Mo. 5 known exactly  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 10<sup>th</sup> 1943 to April 23<sup>rd</sup> 1947;  
 that I last saw him alive on April 23<sup>rd</sup> 1947;  
 and that death occurred on the date and hour stated above.

8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Coronary Occlusion  
 Duration \_\_\_\_\_

9. Birthplace Hennietta Mo. 0  
 (City, town, or county) (State or foreign country)

Due to myocardial insufficiency (Congestive Heart Failure)  
 Due to Cardio-renal-Vascular Disease

10. Usual occupation Labourer

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Major findings: Of operations 93H

MOTHER FATHER { 12. Name unknown 9  
 13. Birthplace unknown (City, town, or county) (State or foreign country)

Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER { 14. Maiden name unknown  
 15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Roscoe A. King

22. If death was due to external causes, fill in the following:

(b) Address 1106 E 22<sup>nd</sup> St, Kansas City, Mo.

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) Burial (b) Date thereof 4-29-1947  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation Holston, Mo

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

18. (a) Signature of funeral director J. B. Greenup  
 (b) Address Jackson, Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

19. (a) 4-26-47 (b) D. B. Suter  
 (Date received local registrar) (Registrar's signature) 43

23. Signature D. B. Suter (M. D. or other) DO.  
 Address Jackson, Mo. Date signed 4/26/47

RECEIVED

District Health Officer No. 4

Number 447-604

4-30-47

MAY 14 1947

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Gene C. Crockett

Licensed Embalmer No. 4327

P. O. Address Jackson, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.